DEPARTMENT OF HEALTH AND HOSPITALS
Aging and Adult Services

Clinical Assessment Protocols Summary Instructions

X=Triggered: Addressed Here **O**=Triggered: Addressed in Another Category **A**=Triggered: Participant does NOT want to address **N**=NOT Triggered: Participant wants to plan	1. Mark the CAPs triggered that are important to the participant and he/she wishes to address, by indicating an X, O, A, or N. "A"- Participant does not want to address. See the intervention section below for further clarification and an example. 2. Include CAPs that are also concerns to the assessor and/or family even if the participant had chosen not to address. These CAPs can be addressed by the assessor in the interventions and goals (i.e. if the assessor is concerned with the environment, he/she will address).	
Related CAPs	List any CAPs that relate to each other from another CAP area that will be care planned together. Address goals and interventions for "shared" CAPs or correlated CAPs on one CAP Summary page in the Plan of Care (POC).	
Caps Goals: There should be a goal for each addressed CAP. The goal may be short or long term, but does not need to be both.	Short term goals – can be resolved within 3 months (e.g. Son will fix the front steps). It is acceptable to include the intervention in the short term goal section or in the intervention section, as long as the intervention for the short term goal is addressed somewhere. *Example*: **Environmental** – Repair steps at front door. Son will fix the front steps.	Long term goals – address ongoing issues and issues that cannot be resolved in 3 months or less. In creating goals, the assessor does not have to include triggering language (prevent, monitor, and/or improve). You can mix and/or combine the trigger level language; such as, continue to monitor to prevent decline in... Identify the CAP(s) that the goal is addressing for both short term and long term goals. *Example*: **Pressure Ulcers, Urinary Incontinence, and Bowel Management** – Maintain skin integrity by monitoring incontinence.
Intervention needed & participant preferences for family/informal supports Address activities performed by unpaid individuals	There must be interventions for every long term goal. Writing an intervention: Step 1. Review the CAP objective. Step 2. Review the items that triggered the CAP. Step 3. Write an intervention to address the first 2 steps. The intervention may need to be written for each item that triggered a particular CAP **OR** just the overall objective as necessary. Assessor will need to use professional judgment to determine which approach is the most appropriate. *Objective Example:* **Psychotropic Drug CAP**: On the MDS-HC assessment, the Psychotropic Drug CAP was triggered for Mrs. Cadillac because she currently takes an antidepressant. The objective of this CAP is to determine if the psychotropic medications are causing any possible, problematic side effects. The assessor should consider the fact that the items that triggered the CAP may be possible side effects of the medication and write an intervention for this instead of writing an intervention for each possible side effect that may have triggered this CAP. *Item that triggered the CAP Example:* **Cardio-Respiratory CAP**: On the MDS-HC assessment, the Cardio-Respiratory CAP was triggered for Mrs. Sedan because she was short of breath. The goal and intervention would specifically address shortness of breath. Person Specific/Person Centered Planning (PCP) must be incorporated when applicable in the POC. Identify	

	Who, What, When, and Where for each intervention. CAPs that identify risks (actual or potential) and CAPs important to the individual should include specific information in the interventions to decrease the risks. Step 1: Review last year's critical incident reports (CIRs) and all support coordination documentation (SCD). Step 2: Look for chronic problems and any identified trends. Step 3: Address the working approaches in the appropriate CAP/goal/intervention. *Example:* In the past year, the participant had several falls. The CIR fall assessment and fall analysis shows that implementing staff to assist in transferring, having hand rails installed in the bathroom and PERS in the home has reduced falls. On the POC CAP issue category, the assessor would address the **Fall** CAP by incorporating the interventions that are working for the participant. Information indicating how medications are administered and who administers them should be included in the appropriate CAP. *Example* for *Medication Administration*: CAP- **IADL/Medication Management**: Mr. Truck's Home Health nurse fills his pill box and he is able to self-administer his medications. Information indicating who performs health-related tasks (e.g. catheterization, tube feeding, tracheotomy suctioning, etc.) should be included. *Example for Health-Related Task*: CAP- **Urinary Incontinence**: His daughter has been trained and is able to manage his catheter. Assess what non-waiver/informal resources are needed and identify them within the appropriate CAP section, if applicable. ADL/IADL tasks and subtasks **should not** be addressed in detail, but should include person specific/person centered information. Based on Mr. Car's MDS-HC assessment, he needs help with bathing, dressing, and toileting. *Example*: Mr. Car needs assistance with bathing, getting dressed, and toileting. Mr. Car likes to bathe before breakfast. He takes a shower every day except Saturdays. On Saturdays, he prefers to take a tub bath. "A"- Participant does not want to address Assessor will need to evaluate the risk to health and welfare of the participant and address the CAP accordingly. Assessor determines that this would not be a risk to her health and welfare. No further documentation in the CAPs is needed. The assessor determines that the health and welfare is at risk; therefore, this CAP will be marked "A" but still planned for. *Example*: Ms. Corvette does not want to plan for falls; however, she has an unsteady gait and history of falls. The assessor will complete a goal and intervention to address the health and welfare.

Intervention needed & participant preferences for formal services. Address activities performed by paid individuals and agencies.	Interventions that are specific to formal and informal supports should be addressed in the appropriate sections. Interventions addressed by both formal and informal supports do not have to be repeated. The assessor can refer to the "see above" Family/Informal supports section or give a general statement; such as, "When paid services are unavailable, informal supports will provide assistance needed." Do not repeat information already addressed in interventions or another CAP summary.